Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 27, 2017

Ms. Betsy Hutchinson,
Second Spring South
118 Clark Road
Williamstown, VT 05679-9449

Dear Ms. Hutchinson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on May 24, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

JUN 2 0 2017

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0386 | A. BUILDING: _____ B. WING _____ | C 05/24/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SECOND SPRING SOUTH | 118 CLARK ROAD WILLIAMSTOWN, VT 05679 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| R100 | Initial Comments:<br><br>An unannounced on-site investigation of 2 facility self reports was conducted by the Division of Licensing and Protection on 5/22/17 & 5/23/17 and completed on 5/24/17. Regulatory violations were identified which were unrelated to the reports investigated. Findings include: | R100 | Please See attached Documents. | |
| R136 SS=A | V. RESIDENT CARE AND HOME SERVICES<br><br>5.7. Assessment<br><br>5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the licensed nurse failed to reassess a resident who was due for an annual resident assessment for 1 applicable resident. (Resident #1) Findings include:<br><br>Per review on 5/23/17, Resident #1 was admitted to the Residential Care Home (RCH) on 4/29/15. At the time of admission an assessment was completed, however since the admission assessment (dated 4/29/15) no further reassessments have been completed. This was verified on the morning of 5/24/17 by an agency staff nurse. | R136 | Please note that this is Resident #2.<br><br>As Noted / Jo Ann Tetreault 6/22/17<br>POC Accepted R-136 | |

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 6/14/17 TITLE Program Manager (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| R145 | Continued From page 1 | R145 | | |
| R145 SS=D | V. RESIDENT CARE AND HOME SERVICES<br><br>5.9.c (2)<br><br>Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the licensed nurse failed to revise a resident's plan of care to reflect the care and management of a cast which was applied to the arm/hand of Resident #2. Findings include:<br><br>On 5/5/17 Resident #2 sustained an injury to his/her right hand. After a visit to the emergency department and a follow-up visit to an orthopedic physician, a fiberglass cast was applied on 5/11/17 to the resident's wrist extending to the forearm. Per review of the nursing plan of care, last updated on 7/13/16, it failed to reflect the management/care of the resident's cast to include monitoring the resident's hand/fingers for pain, swelling, discoloration and tingling and/or numbness. There was no direction for the management of the cast when bathing and methods to protect the cast from getting wet. The failure to revise the plan of care was confirmed on the afternoon of 5/22/17 by the per diem licensed nurse. | R145 | Please see attached documents.<br><br>P.O.C. Accepted D. McIntosh 6/22/17 | |

# Collaborative Solutions Corporation

## Second Spring - Williamstown

## Resident/Visitor Incident Report Form

**Section 1 (to be filled out by reporting Staff)**

Date :_____ Time (24hrs):_____ Location: _____

**Residents Involved**:

1) Name:_____D.O.B:_____/_____/_____

2) Name:_____ D.O.B:____/____/____

3) Name:_____ D.O.B:____/____/____

4) Name:_____ D.O.B:____/____/____

Narrative of the incident (what led up to the incident, client presentation prior to incident, events of the incident itself & staff response) use NAPPI documentation principles:

Please use other side of this page if you need more space

**Section 1 (continued)**

Please list Staff present at the time of incident or: check None _____

Staff Name:_____

Staff Name:_____

Staff Name:_____

Staff Name:_____

Staff Name:_____

**Note Written in Chart(s): Y/N Restraint? Y/N (if yes, fill out restraint report)**

**Printed name and signature of staff filling out incident report:**

Name:_____

Signature:_____ Date:__/__/____

**Outside Agencies Used: Police ____ Ambulance____ Fire____ Crisis Screeners____**

## SECTION 2

**Overall outcome: (to be filled out by Team Leader, Nurse, Med Delegated Staff)**

_____

_____

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**I have verified that this incident report is complete and all required documentation has been completed satisfactorily.**

Name:_____

Signature:_____ Date:__/____/_____

**Check Management Personnel Contacted in accordance with emergency calling protocols:**

**Director_____ Training and Compliance____ Nurse Manager_____**

**Operations Officer_____ Program Manager_____ Admissions Coordinator_____**

**Other**_____

_____

**Nurse Reviewed: Y N Name:**_____ **Date:**_____

**Care Plan updated: Y N, if no, why**_____

## Section 3

**Nurse's Report if applicable:**

**Primary Care Provider / Prescriber Notified: Y/N** **Nurse Manager Notified: Y/N**
**Nursing Note Completed: Y/N**

Name:_____

Signature:_____ Date:___/____/_____

## Section 4

**On Site Review of Incident:** **(filled out by program manager or nurse team leader)**

**All necessary documentation (charts, safety sheets, check sheets etc) have been reviewed by this reviewer Y/N**
**Documentation meets standards Y/N**

**Name:**_____

**Signature**_____ **Date Reviewed:**_____

## Section 5

**Forwarding to Compliance for review**

**Does this incident need to be referred to Training and Compliance for review? Y/N**

Comments to Compliance:

_____
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Name:_____

Signature:_____ Date: ___/___/_____

**Compliance Coordinator Follow-up:**

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Name:_____

Signature:_____ Date:___/___/_____

APS – L&P - DMH Report Warranted? Y/N
Date Report(s) Made:_____

Post Incident Review Warranted Y/N
Date of PIR:_____

# Resident Assessment Renewals

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# *Collaborative Solutions Corporation*

## Second Spring South Plan of Correction

### Complaint Investigation

### 05 - 24 - 17

| Deficiency and Corrective Action | How Monitored | Person Responsible | Completion Date |
|---|---|---|---|
| 1. 5.7 Assessment<br>5.7c Each resident shall also be reassessed annually and at any point in which there is a changed in the resident's physical and mental condition.<br><br>This REQUIREMENT is not as evidenced by:<br><br>Based on record of review and staff interview the licensed nurse failed to reassess a resident who was due for an annual resident assessment for 1 applicable resident (Resident #2) Findings include:<br><br>Per review on 5/23/17, Resident #2 was admitted to the Residential Care Home (RCH) on 4/29/15. At the time of admission an assessment was completed, however since the admission assessment (dated 4/29/15) no further assessments have been completed. This was verified on the morning of 5/24/17 by an agency staff nurse. | A Resident Assessment Renewal form will be posted where it can be seen by nursing staff. Nursing will update the form when new residents arrive. (Attached) | Nurse | 6/16/17<br><br>5.7c<br>6/22/17<br>POC Accepted |
| 2. 5.9.c (2)<br>Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being.<br><br>This REQUIREMENT is not as evidenced by:<br>Based on staff interview and record review, the licensed | We have updated our Incident Report (IR) to include a section for the nurse to indicate that she has reviewed the IR and to indicate whether the Nursing Care Plan has been update or not. (Attached) | Nurse | 6/16/17 |

| | | | |
|---|---|---|---|
| nurse failed to revise a resident's plan of care to reflect the care and management of a cast which was applied to the arm/hand of Resident #2. Findings include:<br><br>On 5/5/17 Resident #2 sustained an injury to his/her right hand. After a visit to the emergency department and a follow-up visit to an orthopedic physician, a fiberglass cast applied on 5/11/17 to the resident's wrist extending to the forearm. Per review of the nursing plan or care, last updated 7/13/16, it failed to reflect the management/care of the resident's cast to include monitoring the resident's hand/fingers for pain, swelling, discoloration and tingling and/or numbness. There was no direction for the methods to protect the cast from getting wet. The failure to revise the plan of care was confirmed on the afternoon of 5/22/17 by the per diem licensed nurse. | | | 5.9 c(2) 6/20/17 POC accepted |
| 3. | | | |